weekly consumption than 21 units. Common sense and scientific evidence suggest that some of these problems are more strongly associated with extreme consumption on single occasions than total consumption over a particular period (N Kreitman and J C Duffy, eighth annual alcohol epidemiology symposium, Helsinki, 1982).

It might be argued that as there is no scientific basis for the limits of 21 and 14 units a week new scientific information can be regarded as irrelevant. Such an attitude is short sighted and ultimately counterproductive, allowing legitimate public health interests and health advocacy to be portrayed as either ill informed or incompetent. Greater public health gain might result from giving advice that is both coherent and credible.

JOHN C DUFFY

Alcohol Research Group,
Department of Psychiatry,
University of Edinburgh,
Royal Edinburgh Hospital,
Edinburgh EH10 5HF

- 1 Kemm J. Alcohol and heart disease: the implications of the U-shaped curve. *BMJ* 1990;307:1373-4. (27 November.)
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Wine glass holds more than one unit

EDITOR,—Patients are often accused of underestimating the amount of alcohol they drink, but do we as a profession not collude with this by stating that a glass of wine equals one unit of alcohol? Only wine with 8% alcohol fulfils this. As most wine is 12% or 13% alcohol and most people are liberal pourers would it not be more honest to say that a glass of wine is almost two units? Increasingly, beer and lager in cans and bottles is 6% to 8% alcohol. Should we not change our statements about these drinks too?

G TAYLOR

Newcastle upon Tyne NE2 4RQ

- 1 Kemm J. Alcohol and heart disease: the implications of the U-shaped curve. *BMJ* 1993;307:1373-4. (27 November.)

Informed consent

Consent requires a flexible approach

EDITOR,—We wish to respond to the correspondents who replied to our article on the distress that fully informed consent for randomised trials of treatment of cancer can create.^{1,2} We are disappointed that some of them have concluded that we are against informed consent. We emphasised throughout our article that we are in favour of informed consent; it is the nature and degree of consent for individual patients that concern us. We advocate a flexible approach, but several correspondents have not fully understood this.

Mark Emberton and colleagues misrepresent our position. They quote studies that purport to show that patients want more detailed information and are not harmed by receiving it. They miss the point with the examples they quote. Fallowfield *et al*'s study concerned only those patients accepting randomisation and did not address the issue we raised. The other example they quote is of consent

in a randomised trial of surgery for hernia, which is clearly not comparable and is therefore unhelpful. These studies of patients' attitudes do not simulate the clinical situation in which a patient with newly diagnosed cancer faces discussion of a complex randomisation (sometimes with more than two alternative treatments). Patients are not a homogeneous group in this situation and should not be treated as if they are. They are individual people with a right to as much information as they want at that moment. The difficulty is to ascertain this without the doctor imposing his or her own view (which is usually the case in routine practice outside trials). We do not "use the argument that seeking normal consent . . . results in confusion and distress" in order to "challenge informed consent." Still less do we "pretend that the solution to the issue lies in not informing at all." We are in favour of informed consent and spend our professional lives talking to patients about their treatment. We believe that patients can be overwhelmed by too much information at the wrong time. Emberton and colleagues should not therefore misrepresent our view in the way that they do.

Laurence Gerlis says that we have "missed the boat" and quotes the current bureaucratic guidelines in the United States and Europe. It is never too late for common sense. Laws and ethical guidelines can be changed. Josephine G Wong is wrong to state that there is a conflict between the scientific needs of a randomised trial and a doctor's obligation to act in his or her patient's best interest. The whole point is that the trial position must be ethical to begin with. Again we refute her suggestion that we wish to "deprive the patient of information." We agree with her that gaining consent to treatment, whether in a trial or not, takes considerable time and effort. It is those patients who are damaged and upset by an insistence on inappropriate methods of imparting information who concern us.

J P Walsworth-Bell proposes a quasipsychiatric interpretation of our perceived distress, but we do not accept the explanation that we are unhappy at questioning the potential of a new treatment. We enjoy doing just that and believe profoundly in the scientific imperative for randomisation since new does not always equal better. We agree that doctors need help in how to approach the problem of informed consent and other aspects of communication with patients with cancer. For this reason, both of us participated in the production of a successful series of training programmes based on videos, for senior oncologists.

O A Adedeji states that patients would be told "less and less" if flexibility in the timing, wording, and degree of informed consent was adopted. We believe that the reverse would be the case. At present most patients are treated outside trials, sometimes because of these difficulties in gaining informed consent. How does Adedeji know what this overwhelming majority of patients are told? Do they have the full disclosure that Adedeji advocates? We doubt it.

Finally, the patient (Hazel Thornton) and the parent (Richard Keatinge) show that patients are indeed prepared to accept that they are not all the same and that advice about treatment outside trials may sometimes conceal dogmatic or ignorant medical attitudes. There are no ethical guidelines or legislation for fully informed consent for patients in this far more common situation.

R L SOUHAM

University College London Medical School,
London WC1

J S TOBIAS

Meyerstein Institute of Clinical Oncology,
Middlesex Hospital,
London W1N 8AA

- 1 Tobias J, Souhami R. Fully informed consent can be needlessly cruel. *BMJ* 1993;307:1199-201. (6 November.)
- 2 Correspondence. Informed consent in clinical trials. *BMJ* 1993;307:1494-7. (4 December.)

Reactionary approach inhibits progress

EDITOR,—I suppose it was predictable that the paper by Jeffrey S Tobias and Robert L Souhami would provoke a barrage of ill informed and hostile comment.¹ I particularly took exception to the letter by Emberton and colleagues,² which cited work from my own group³ to justify their reactionary position.

The Cancer Research Campaign trial for the surgical management of primary breast cancer set out to recruit 2000 patients randomised between mastectomy and breast conserving techniques. After three years we had to admit defeat, as only 150 patients had been recruited. This small subset was used for the psychological inventory at long term follow up to determine the qualitative outcomes of these radically different therapeutic regimens.³

The real issue is what happened to the 1850 patients who should have been recruited and presumably were refused entry into the trial and, furthermore, what happened to the 75 000 women who developed breast cancer in the United Kingdom during that period and were treated by mastectomy or breast conserving techniques according to the whim of the general surgeon. During this period in the late '70s and early '80s, when there was genuine equipoise as to the relative merits of these two approaches, patients outside the trial were kept in the dark and not offered a choice, whereas those patients fully informed about the uncertainty were frightened off entry into the trial or forced to make decisions that, on the one hand, could lead to the unnecessary loss of their breasts and, on the other hand, the unnecessary loss of their life.

It is truly disingenuous of Emberton *et al* to compare this with a randomised trial looking at different techniques for the repair of an inguinal hernia.⁴ I would imagine that most patients would be totally indifferent to the surgical techniques used, particularly as the groin is hardly a zone of sexual attraction or sexual identity.

Furthermore, the leisurely contemplation of the anatomy of the inguinal canal cannot be compared with the agonising decision facing a middle aged man with crushing chest pain when the politically correct position demands fully informed consent before he can be randomised into a trial of clot busting drugs.

M BAUM

Royal Marsden Hospital,
London SW3 6JJ

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Methods of consent should be tested experimentally

EDITOR,—Jeffrey S Tobias and Robert L Souhami use their clinical experiences to argue that inviting patients to make informed decisions may not be what patients want and sometimes results in more harm than good.¹ There is some empirical evidence to support this supposition. People vary in the role they wish to have in decisions regarding treatment. Some of this variation is due to individual differences in coping style.² Recent research suggests that a more important influence is the severity of the threat being faced. While most people in the general population think that they would want to play a part in determining their own treatment if they developed cancer, most patients with cancer want a doctor to make decisions on their behalf.³

Tobias and Souhami go further and suggest that